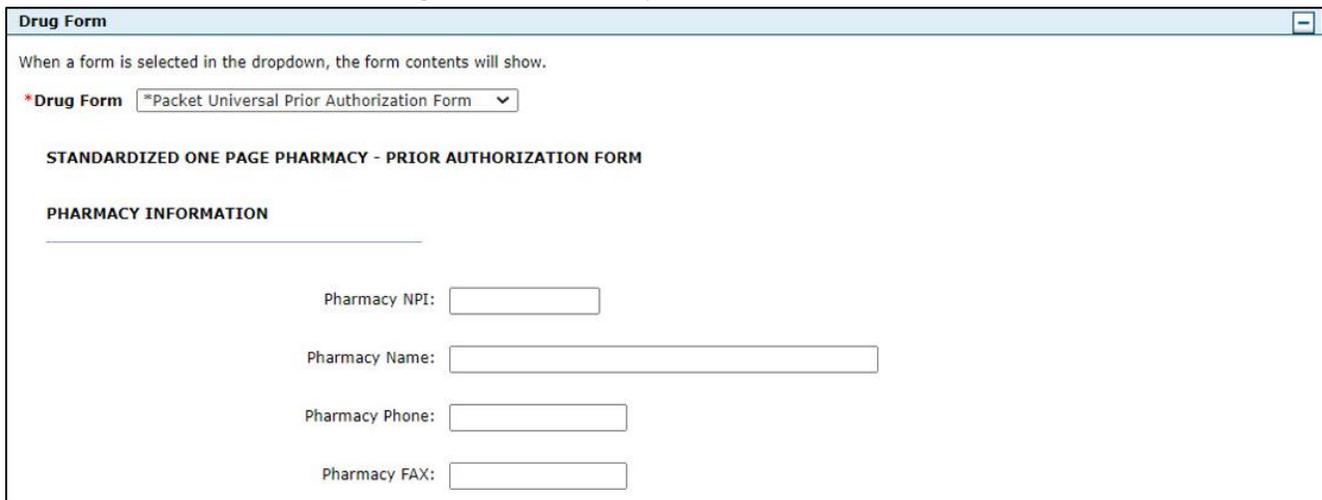


## Job Aid

# PRP-102 Universal PA Form Rules

The Universal PA Form is used in Healthcare Portal as part of the PA request in the Provider Portal. The Universal PA Form has been divided into several figures and tables describing the information that should be entered in the fields. For information on section Pharmacy Information, see Figure 1: Pharmacy Information Section.

**Figure 1: Pharmacy Information Section**



Drug Form

When a form is selected in the dropdown, the form contents will show.

\*Drug Form

**STANDARDIZED ONE PAGE PHARMACY - PRIOR AUTHORIZATION FORM**

**PHARMACY INFORMATION**

Pharmacy NPI:

Pharmacy Name:

Pharmacy Phone:

Pharmacy FAX:

For information in the table, see Table 1: Pharmacy Information Fields. Table 1

**Table 1: Pharmacy Information Fields**

Field Name	Description	Format
Pharmacy NPI	NPI Identifier for the pharmacy on the PA request.	Character
Pharmacy Name	Name of pharmacy on the PA request	Character
Pharmacy Phone	Phone number for the pharmacy on the PA request.	Character
Pharmacy FAX:	FAX number for the pharmacy on the PA request.	Character

For information on section Clinical Information see, Figure 2: Clinical Information Section.

**Figure 2: Clinical Information Section**

**CLINICAL INFORMATION**

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Requested PA Start Date:  

Requested PA End Date:  

Drug/Product Requested:

Strength:

Quantity:

Days Supply:

RX Refills:

Diagnosis or ICD-10 Code(s):

Hospital Discharge

Additional Medical Justification Attached

Medications received through coupons and/or samples are not acceptable as justification

For information in the table, see Table 2: Clinical Information Fields.

**Table 2: Clinical Information Fields**

Field Name	Description	Format
Requested PA Start Date	The start of the timeframe for which the service is requested to be performed/dispensed on the line item.	Date
Requested PA End Date	The end of the timeframe for which the service is requested to be performed/dispensed on the line item.	Date
Drug/Product Requested	Description of the drug that is being requested.	Character
Strength	Refers to the potency of the drug and is usually expressed in a metric quantity, such as 500 MG.	Character
Quantity	Quantity of the drug requested.	Character
Days' Supply	The number of days for which the drug should be prescribed.	Character
RX Refills	Number of refills requested.	Character
Diagnosis or ICD-10 Code(s)	Description or ICD-10 code representing the Member's diagnosis.	Character

Hospital Discharge	Checkbox indicating that this request is part of a hospital discharge.	Checkbox
Additional Medical Justification Attached	Checkbox indicating that documentation with additional medical justification has been attached to the PA request.	Checkbox

For information on section Signature, see: Figure 3: Signature Section.

**Figure 3: Signature Section**

*Prescribing provider's signature (signature of anyone other than the provider is not acceptable)*

You will be submitting a Prior Authorization request electronically. Therefore, your signature on this request will be electronic. By submitting this request electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

I understand that my electronic signature is equivalent to written signature.

\*  I accept

I certify that all information provided is accurate and appropriately documented in the patient's medical chart.

\* Signature required:

(Entering your name in the box above will constitute your electronic signature.)

Submission Date: 02/16/2022 10:22 AM

For information in the table, see Table 3: Signature Fields.

**Table 3: Signature Fields**

Field Name	Description	Format
I accept	Checkbox acknowledging the statement "I understand that my electronic signature is equivalent to written signature." Required field.	Checkbox
Signature required	Electronic signature required for submission of the PA request.	Character
Submission Date	Automatically populated	Date

For information on section Universal PA Request, see: Figure 4: Universal PA Request Questions 1 & 2.

**Figure 4: Universal PA Request Questions 1 & 2**

**Universal Prior Authorization Request**

Notice: Before submitting a PA request, check for options not requiring PA on the current PDL found at <https://medicaid.ms.gov/providers/pharmacy/preferred-drug-list/>. Medicaid providers are encouraged to use equally efficacious and cost-saving preferred agents whenever possible. Prior drugs used must be reflected in paid pharmacy claims.

1. Is the diagnosis for the agent requested a FDA approved indication?  Yes  No  NA  
Yes (see #2), No (see #3)

If **No**, then please sign the following waiver:

Waiver (if applicable): I am aware that this drug is not FDA approved or has limitations for use due to:  the member's age  medical condition and/or diagnosis

See waiver signature required at the end of form to attest that the medical necessity outweighs the risk for this/these medication(s).

2. Is there a preferred agent on the PDL used for the treatment for this diagnosis?  Yes  No  NA  
Yes (see #3), No (see #4)

For information in the table, see Table 4: Universal PA Request Fields Questions 1 & 2.

**Table 4: Universal PA Request Fields Questions 1 & 2**

Field Name	Description	Format
1. Is the diagnosis FDA approved indication	Yes/No/NA selection to indicate if the diagnosis for the agent requested an FDA approved indication. Yes (see #2), No (see #3)	Radio button
1. Is the diagnosis (If No)	If the response to #1 No, sign waiver due to member's age, medical condition, or diagnosis.	Checkbox
2. Is there a preferred agent on the PDL	Yes/No/NA selection to indicate if there is a preferred agent on the PDL used for the treatment for this diagnosis. Yes (see #3), No (see #4).	radio button

1. For information on section Universal PA Request Questions 3 & 4, see: Figure 5: Universal PA Request Questions 3 & 4.

**Figure 5: Universal PA Request Questions 3 & 4**

3. Has the patient experienced any of the following regarding use of the preferred product(s): treatment failure, a condition that prevents use, a potential drug interaction, and/or intolerable side effects?

If **Yes**, please give a detailed explanation:

**1st Drug:**

Length of Therapy:

**2nd Drug:**

Length of Therapy:

*Attach additional documentation of other treatment failures with preferred drugs if necessary. If no previous preferred drug usage, then additional medical justification must be provided.*

4. Please provide the treatment plan for this diagnosis including, but not limited to: pertinent medical history, relevant lab values, concurrent medications, treatment tried and reason (if known) for failure.

Printed Name of Prescribing Provider:

Date:  

For information in the table, see Table 5: Universal PA Request Fields Questions 3 & 4.

**Table 5: Universal PA Request Fields Questions 3 & 4**

Field Name	Description	Format
3. Has patient experienced any of the following	Free form textbox to enter a detailed explanation if the patient has experienced any of the following regarding use of the preferred product(s): treatment failure, a condition that prevents use, a potential drug interaction, and/or intolerable side effects	Character
1st Drug & 2nd Drug	Name of drug on the PA request.	Character
Length of Therapy (1st and 2nd Drug)	Length of therapy for the drug on the PA request.	Character
4. Please provide treatment plan	Free form textbox to provide treatment plan for the diagnosis including, but not limited to pertinent medical history, relevant lab values, concurrent medications, treatment tried and reason (if known) for failure.	Character
Printed Name of Prescribing Provider	Printed name of the provider submitting the PA request.	Character
Date	Enter date in mm/dd/yyyy format.	Date

2. For information on section Waiver, see: Figure 6: Waiver Section.

### Figure 6: Waiver Section

**If applicable, please attest to waiver by checking box and providing your signature below:**

**Waiver: I attest that the medical necessity outweighs the risk for this/these medication(s).**

Printed Name of Prescribing Provider:

Date: 02/16/2022 10:22 AM

SUBMISSION AND/OR APPROVAL OF A DRUG PRIOR AUTHORIZATION REQUEST DOES NOT GUARANTEE MEDICAID PAYMENT FOR PHARMACY PRODUCTS OR THE AMOUNT OF PAYMENT. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

**Confidentiality Notice:** This communication, including any attachments, is for the sole use of intended recipients(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply telephone (1-877-537-0722) or fax (1-877-537-0720) and destroy all copies of the original message.

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3. For information in the table, see For information on section Waiver, see: Figure 6: Waiver Section.  
Figure 6: Waiver Section.

**Table 6: Waiver Fields**

Field Name	Description	Format
Waiver	Attestation to waiver that medical necessity outweighs the risk for this/these medication(s).	Checkbox
Printed Name of Prescribing Provider	Printed name of the provider submitting the PA request.	Character
Date	System Date	Date